

Resident: _____

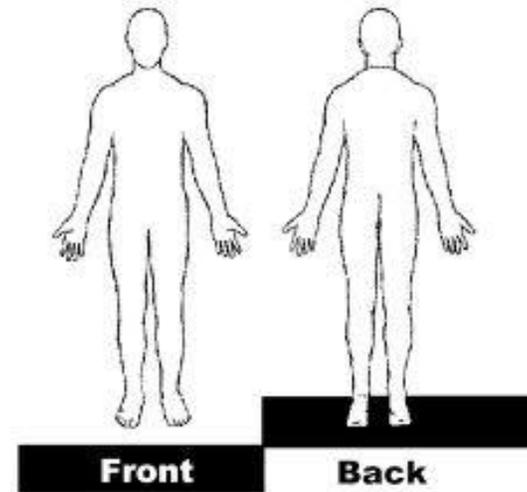
Date Completed: _____

WOUND ASSESSMENT

To be completed by the Delegating Nurse/Case Manager and attached to the applicable nursing assessment.

Pressure Ulcer Stages		Number of Pressure Ulcers
Stage 1:	Redness of intact skin; warmth, edema, hardness, or discolored skin.	
Stage 2:	Partial thickness skin loss of epidermis and/or dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as intact or open/ruptured serum-filled blister.	
Stage 3:	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling.	
Stage 4:	Full thickness skin loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	
	(1) Unstageable: Known or likely but unstageable due to non-removable dressing or device.	
	(2) Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	
	(3) Unstageable: Suspected deep tissue injury in evolution.	

Location of Ulcers- Use the diagram to show the location of each pressure ulcer or wound.



Comments: For each ulcer or wound, indicate the measurement (in centimeters), drainage, type, and any other significant characteristics.

<i>How to Measure an Ulcer:</i>	Length: Longest length Width: Width of same ulcer; greatest width perpendicular to the length Depth: Depth of same ulcer; from visible surface to the deepest area
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RN's Signature: _____